National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2002

Section: Program Data--Operating Authority Terms

1915(b)(1)	***Service Arrangement provision***. The State may restrict the provider from or through whom beneficiaries may obtain services.
1915(b)(2)	***Locality as Central Broker provision***. Under this provision, localities may assist beneficiaries in selecting a primary care provider.
1915(b)(3)	***Sharing of Cost Savings provision***. The State may share cost savings, in the form of additional services, with beneficiaries.
1915(b)(4)	***Restriction of Beneficiaries to Specified Providers provision***. Under this provision, States may require beneficiaries to obtain services only from specific providers.
1115(a)	***Research and Demonstration Clause***. The State utilizes specific authority within Section 1115(a) of the Social Security Act to allow the State to provide services through the vehicle of a Research and Demonstration Health Care Reform waiver program.
1932(a)	***State Option to use Managed Care.*** This section of the Act permits States to enroll their Medicaid beneficiaries in managed care entities on a mandatory basis without section 1915(b) or 1115 waiver authority.
1902(a)(1)	***Statewideness***. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.
1902(a)(10)(B)	***Comparability of Services***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance. Waiving 1902(a)(10)(B) indicates that the scope of services offered to beneficiaries enrolled in this program are broader than those offered to beneficiaries not enrolled in the program.

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2002

1902(a)(23)

Freedom of Choice. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.

Section: Service Delivery--Managed Care Entity Terms

PCCM

Primary Care Case Management (PCCM) Provider is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PHPs which act as PCCMs.

PHP

Prepaid Health Plan is a prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis. Comprehensive services are defined in 42 CFR 434.21(B). There are several types of PHPs that States use to deliver a range of services. For example, a Mental Health (MH) PHP is a managed care entity that provides only mental health services. This category does not include those PHPs which contract as primary care case management.

MCO

Managed Care Organization is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.

HIO

Health Insuring Organization is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2002

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through fee-for-service payments, plus in most cases, a case management fee.
Full Capitation	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through capitation.
Partial Capitation	The plan or Primary Care Case Manager is paid for providing services to enrollees through a combination of capitation and fee-for-service reimbursements.

Section: Quality Activity Terms

Accreditation for Deeming	Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.
Accreditation for Participation	State requirement that plans must be accredited to participate in the Medicaid managed care program.
Consumer Self-Report Data	Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO or PHP. The survey may be conducted by the State or a contractor to the State.
Encounter Data	Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO or PHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".

National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2002

Enrollee Hotlines	Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO/PHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.
Focused Studies	State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO/PHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO/PHP staff or more than one of these entities may perform such studies at the discretion of the State.
MCO/PHP Standards	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PHP must have in order to participate in the Medicaid program.
Monitoring of MCO/PHP Standards	Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.
Ombudsman	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.
On-Site Reviews	Reviews performed on-site at the MCO/PHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.
Performance Improvement Projects	Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis

	and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PHPs choosing or prescribed by the State.
Performance Measures	Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PHP.
Provider Data	Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.
HEDIS Measures from Encounter Data	*Health Plan Employer Data and Information Set (HEDIS)* measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).
EQRO	Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.